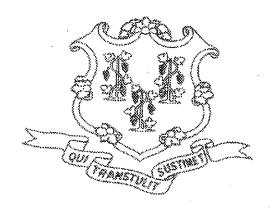
### **State of Connecticut**



### **Annual Report of Long-Term Care Facility**Cost Year 2019

Name of Facility (as								
Meriden Care Center	, LLC							
Address (No. & Street	et, City, State, Z	Zip Code)			-			
33 Roy St. Meriden,	CT 06450							
Type of Facility						*******		
Chronic and C Nursing Home	Convalescent e only (CCNH)	_	Rest Home with Supervision only (RHNS)	_		(Specify)		
Report for Year Begi 10/1/2018	nning		Report for Year 9/30/2019	Ending				***************************************
		***************************************						
License Numbers:		CCNH 2448	RHNS		(Specify)		Me	edicare Provider 07-5337
* * 1' . '1 Th	1							
Medicaid Provider N	umbers:	CC 10660	CNH	RF	INS		IC	F-IID
For Department Us	e Only							
Sequence Number	Signed and	Date	Sequence Nu	ımber	G: 1			
Assigned	Notarized	Received	Assigne		Signed a	nd Notariz	ed	Date Received
***************************************								

### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2019	1	37

### Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Meriden Care Center, LLC [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)		Date	Signed (Owner)	Date
Printed Name (Administrator) Raymond Hackling			Printed Name (Owner) Chris Wright	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Address of Notary Public				/_/_/

(Notary Seal)

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### State of Connecticut **Department of Social Services**

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page	of
				1A	37
Name of Facility		Period Cov	ered:	From	То
Meriden Care Center, LLC				10/1/2018	9/30/2019
Address of Facility					
33 Roy St. Meriden, CT 06450					
Report Prepared By		Phone Nun		Date	
iCare Management, LLC		860-570-2	140	2/15/2020	
Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$				
5. All other wages paid	\$				
6. Total Wages Paid	\$				
7. Total salaries paid	\$				
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$				

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

**DO NOT include Fringe Benefit Costs.** 

### General Information and Questionnaire Type of Facility - Organization Structure

	131	37 05	117.	D . 0 77			
	í	one No. of Fac	ality	Report for Ye	ar Ended	Page	of
	[203	3-237-8457		9/30/2019		2	37
Name of Facility (as shown on license)				Street, City, Sto	ite, Zip)		
Meriden Care Center, LLC	. ,		Merid	len, CT 06450			
CCNH		RHNS		(Specify)			Provider No.
License Numbers: 244	8					07-5337	
Type of Facility (Check appropriate box(es))							
Chronic and Convalescent Nursing Home only (CCNH)		st Home with l pervision only			(Specify)		
Type of Ownership (Check appropriate box)							
	_						
O Proprietorship O LLC O Partnership	0	Profit Corp.	0	Non-Profit Cor	р. О	Government	O Trust
			Date	Opened	Date Clo	sed	
If this facility opened or closed during report year provid	e:			•			
Has there been any change in ownership			•				
or operation during this report year?	0	Yes	•	No	If "Yes,"	explain fully	<i>.</i>
					<u> </u>	<del></del>	
Administrator							
Name of Administrator				Nursing Ho	ome		
Raymond Hackling				Administrat	or's	000853	
				License 1	No.:		
Other Operators/Owners who are assistant administrator	s (full	or part time)	of thi	s facility.	· · · · · ·		
Name				License 1	No.:		
				, ,			
					1		
		THE STATE OF THE S					

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### General Information and Questionnaire Partners/Members

Name of Facility Meriden Care Center, LLC		License No.	Report for 9/30/2019	Year Ended	Page 3	of 37
Legal Name of Par	tnershin/LC	Business A		State(s) and		s) in
Meriden Care Center, LLC	anorsinp/EEA	33 Roy St. Meri 06450		CT	Registered	
Name of Partners/Members	Business A	ddress		Title	% Ov	vned
Executive Advisors, LLC	341 Bidwell St. Manch	ester, CT 06040	Member		47.	5
Apex Advisors LLC	341 Bidwell St. Manch	ester, CT 06040	Member		47.	5
Christopher Wright	341 Bidwell St. Manch	ester, CT 06040	Member		5	
				***************************************		
						.,
may puls.		***************************************				

### General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year	Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2019		3A	37
If this facility is owned or operated as a corpo	ration, provide t	he following inform	ation:		
Legal Name of Corporation		ness Address	State(s) in W	hich Incorp	orated
			· · · · · · · · · · · · · · · · · · ·	***************************************	
Name of Directors Officers	D:	A 11	77° -1	No. S	hares
Name of Directors, Officers	Busi	ness Address	Title	Held by	y Each
				•	
Names of Stockholders Owning at Least 10%					
of Shares					
		···········			
					****
	L-Laboratoria				
		****			

### General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2019	3B	37
If this facility is owned or operated as an individua	al proprietorship, p	provide the following informa	tion:	
	ner(s) of Facility			
	A STATE OF THE STA			
				•
			····	
		- The state of the		
	****			
			***************************************	, w
Aprillant Aprill		**************************************		

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Related Parties\*

Name of Facility		Lice	License No.	1	Report for Year Ended อเรเติกาจ		Page 4	of 37
						_		
Name of Related	Business	* 8 8 E	Also Provides Goods/Services to Non-Related Parties	rides ices to Parties	Description of Goods/Services	Indicate Where Costs are Included in Annual Report	Cost	Actual Cost to the Related
Individual or Company	Address	Yes	ž	**%	Provided	Page # / Line #	Reported	Party
Bidwell Care Center, LLC	333 Bidwe Manchest		<b> </b>		Shared Employees		(3.899)	3,899
Chelsea Place Care Center, LLC					Shared Employees		(4,424)	424
Chestnut Point Care Center, LLC	171 P Wind				Shared Employees		(1,530)	1,530
Farmington Care Center, LLC	20 Scott Swamp Rd. Farmington, CT 06032				Shared Employees		(2,427)	2,427
Kettle Brook Care Center, LLC	96 Prospect Hill Rd. East Windsor, CT 06088				Shared Employees		(2,647)	2,647
Meriden Care Center, LLC (Silver Springs)	33 Roy St. Meriden, CT 06450				Shared Employees		1	,
Trinity Hill Care Center, LLC	151 Hillside Ave. Hartford, CT 06106				Shared Employees		16,642	(16,642)
Westside Care	349 Bidwell St. Manchester, CT 06040				Shared Employees		(3.063)	3.063
Care	140 Park Ave. Bloomfield, CT 06002				Shared Employees		(2,825)	2,825
Center	60 West Street, Rocky Hill, CT 06067				Shared Employees		2,879	(2,879)
Universal Healthcare Holdings, LLC					Shared Employees		(10,527)	10,527
Touchpoints at Homecare LLC	1838 Silas Deane Hwy, Rocky Hill, CT 06067				Shared Employees			
Elevate Counseling Services LLC	341 Bidwell St. Manchester, CT 06040	***************************************			Shared Employees		1	,
Touchpoints Therapy LLC	341 Bidwell St. Manchester, CT 06040				TS/J/J/S	13 5,8,10	328,193	(328,193)
Realty	N/A				Building Lease & Rent	22,22,27 10,9,14		-
iCare Management, LLC	341 Bidwell St. Manchester, CT 06040				iCare Helt-Legal, Postage, Emp Recruitment & Marketing	16, 15 M,E	17,708	(17,708)
iCare Health Management, LLC	341 Bidwell St. Manchester, CT 06040				Shared EEs not part of mgmt agmt		168,128	(168,128)
					Management Services, Direct	20 5j	222,408	(222,408)
			_		Management Services, Indirect	20.2]	201,132	(31,132)
					Managament Services, Aunimistative	7 IN IN	273,6/4	(+10,0%)
All Care Centers,					Chara Common All Daneion and Incurance alone couries land and verious other services	lame and warious other	ar convices	A ANGELO
* Use additional sheets if necessary	ts if necessary.				SHALC COLLINOR TOTA, I CLISIOR and misurance praiss, vocases, s	iegai aila variota our	SI SEI VIVES	

Use additional sheets if necessary,
 \*\* Provide the percentage amount of revenue received from non-related parties.

### General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No.		Report for Year Ended	Page	of
Meriden Care Center, LLC	2448		9/30/2019	5	37
If the facility is licensed as CDH and/or RCH or	r provides AI	DS or TBI	services with special Medicaid	rates, co	sts
must be allocated to CCNH and RHNS as follow			_		
Item			Method of Allocation		
Dietary		Number of	meals served to residents		
Laundry		Number of	pounds processed		
Housekeeping		Number of	square feet serviced		
	1		hours of routine care provided		
Nursing			lassification, i.e., Director (or	-	
		Registered [	Nurses, Licensed Practical Nu	rses, Aide	es and
		Attendants			
Direct Resident Care Consultants			hours of resident care provided	l by EAC	H H
			See listing page 13)		
Maintenance and operation of plant		Square feet			
Property costs (depreciation)		Square feet			
Employee health and welfare		Gross salar			
Management services			e cost center involved		
All other General Administrative expenses			rect and Allocated Costs		
The preparer of this report must answer the following	owing question	ons applical	ble to the cost information prov	zided.	
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why suc	h allocati	on was
costs allocated as required?	O 103	0 110	not made.		
2. Explain the allocation of related company ex	penses and a	ttach copy	of appropriate supporting data.		
3. Did the Facility appropriately allocate and se	elf-disallow d	irect and in	direct costs to non-nursing hor	ne cost ce	enters?
(e.g., Assisted Living, Home Health, Outpati	ient Services,	Adult Day	Care Services, etc.)		
	• Yes	O No	If "No," explain fully why such made	h allocati	ion was
- 110***********************************			not made.		-

State of Connecticut
Annual Report of Long-Term Care Facility
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### General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

SECURE INC. OF MINIMON III MINOS MINORILIS.							
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
Meriden Care Center, LLC			2448	9/30/2019			6 37
	Related * to	d * to					
	Owners,	ers,					
	Operators,	itors,				Annual	
	Officers	cers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Accelerated Care Plus Corp. 4850 Joule Street, Suite A-1 Reno,	0	•	Omnistim Electrotherapy and Omnisound Therapeutic Ultrasound Equipment	05/18/10	I yr with automatic	14,102	14,102
ADP, Inc., One ADP Drive MS-100, Augusta, GA 30909	0	0	uip	06/01/10	60 months & automatic	650'6	9,059
Mail Finance/Neopost New England, 25881 Newtwork Place, Chicago, IL 60673	0	•	Postage Meter Rental		Monthly	1,015	1,015
CIT Finance LLC	0	0	Copier		41949	23,691	23,691
	0	0					
	0	•					
	0	0					
	0	0					
	0	•					
	0	0					

Is a Mileage Log Book Maintained for All Leased Vehicles?

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

Total \*\*\*

0 0

O Yes

\*\* Attach copies of newly acquired leases.

\*\*\* Amount should agree to Page 22, Line 6e.

### **Annual Report of Long-Term Care Facility** CSP-7 Rev. 6/95

### **General Information and Questionnaire Accounting Basis**

Name of Facility	License No.	Report for Year Ended		Page	of
Meriden Care Center, LLC	2448	9/30/2019		7	37
The records of this facility for the p	period covered by this report	were maintained on the following basis:			
• Accrual O Cash O	Modified Cash				
Is the accounting basis for this					WILTON
<del>-</del>	Yes	If "No," explain.			
•	No	ii iio, capiani			
Independent Accounting Firm				·····	
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)	<u> </u>		************
1 O'Connor, Davies LLP		100 Great Meadow Road, Ste 401, Weth		` 06109	
2		, ,	,	30143	
3					
4					
Services Provided by This Firm (de	scribe fully )				-
1 Taxes, financial statements, accounting	g support		\$	8,859	***************************************
2			\$		
3			\$		,
4			<u> </u>		
			<del> </del>	0 D.	
			_	Services Pro	ovided
Are These Charges Reflected in the Evennel	iture Portion of This Donate ICV-	s, Specify Expense Classification and Line No.	\$	8,859	
	15D	ss, Specify Expense Classification and Line No.			
Legal Services Information					
Name of Legal Firm or Independent	t Attorney		T-11	N.T 1	
iCare Health Management, LL0			Telephone 860-570-2		
2 Starble and Harris			860-570-2 860-678-7		
3 Durant Nichols / Robinson & (	Cole, LLP		860-275-8		
		, Murtha Cullina, Jackson Lewis))	000-275-6	200	
5 Starble and Harris, iCare Healt	h Management LLC	**	860-678-7	775 & 860-5	70 2140
Address (No. & Street, City, State,			000 070 7	773 00 000-2	770-2140
1 341 Bidwell Street, Mancheste					
2 32 Main Street, Avon, CT					
3 280 Trumbull St, Hartford, CT					
4					
5 32 Main Street, Avon, CT & 3		ter CT			
Services Provided by This Firm (de.	scribe fully )				
I Lease and contract issues, general lega			S	13,164	
2 Lease and contract issues, general legal			\$		
3 Employment law, arbitrations, contract	t negotiations		\$	(4,460)	
4 Employment Arbitrations, healthcare la	aw		\$	295	
5 Conservatorships & Collections			\$	1,436	
				Services Pro	ovided
			\$	10,435	
Are These Charges Reflected in the Expendi	ture Portion of This Report? If Ye	s, Specify Expense Classification and Line No.	. 9	10,433	
	15E	-			

State of Connecticut
Annual Report of Long-Term Care Facility
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## Schedule of Resident Statistics

Name of Facility Meriden Care Center, LLC			License No. 244	No. 2448			Report for 9/30/2019	Report for Year Ended 9/30/2019	g		Page 8	of 37
					,	Period 10/1 Thru 6/30	1 Thru 6/.	30		Period 7/1 Thru 9/30	Thru 9/3	0
	Total All	Total CCNH	Total RHNS	Total								
	Levels	Level	Level	(Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHINS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	159	159			159	159			159	159		
B. On last day of THIS report period	159	159			159	159			159	159		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	156	156			156	156			157	157		
B. As of midnight of THIS report period	154	154			157	157			154	154		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,507	1,507			1,229	1,229			278	278		
B. Medicaid (Conn.)	49,040	49,040			36,355	36,355			12,685	12,685		
C. Medicaid (other states)												
D. Private Pay	380	380			288	288			92	92		
E. State SSI for RCH												
F. Other (Specify) Insurance	5,943	5,943			4,619	4,619			1,324	1,324		
G. Total Care Days During Period (3A thru F)	56,870	56,870			42,491	42,491			14,379	14,379		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds										•		
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	56,870	56,870			42,491	42,491			14,379	14,379		

**Schedule of Resident Statistics (Cont'd)** 

Name of Facil	lity			Licer	ise No.				Report	for Year	Ended		Page	of
Meriden Care	Center.	LLC		2	2448				_	9/30/201			9	37
4. Were the	ere anv o	hanges	in the certified b	ed ca	pacity du	ring t	he renc	nt vea	r?	0	Yes	ര	No	
		-	llowing informat		paorty au	ւուբ	iio rope	ni you	<b>.</b> :		. •••	J	110	
11 110			Change		Cł	ange	in Bed	s		Car	pacity Afte	er Change		
Date of		RHNS	(Specify)		Lost			Gaine	1		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
	COLUL	1410	(-1))		1000		`			1				
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason fo	or Change
						1								
			*****											
							L	<u> </u>						
5. If there v	vas any	change	in certified bed	apaci	ty during	the r	eport y	ear (as	report	ed in item	4 above)	provide the nun	nber of	
RESIDE	ENT DA	YS for	90 days followir	ig the	change.									
					*****								***************************************	
			Change in R	esider	nt Days					l cc	NH	RHNS	(Spe	cify)
1st chan					•									
2nd ehar														
3rd chan							~~···							
4th chan 6. Number		lante en	d Rates on Septe	mbor	20 of Co	at Va	0.**			<u> </u>				
O. INUITIOEI	Of ICESIC	icilis ali	Medicare	anoer	Medi		41	_		Se	lf-Pay		Other Stat	a Accietad
			managemen		IVICUI	bara		<b>-</b>	· · · · · · · · · · · · · · · · · · ·	I	/11-1 tay		Offici Sta	C Assisted
	Item		CCNH		CNH	RI	HNS	cc	CNH	RE	INS	(Specify)	R.C.H.	ICF-MR
No. of R		1	3		129	101	.1110	-	2	-	1110	(Бреспу)	14.0.11.	ICT-WIK
Per Dien	n Rate													
a. One b		W-7	505.00		249.00				418.00					
	bed rms													
c. Three		e						1						
bed r	rms.			L				<u> </u>				*		
7 Total Nu	umber of	Physica	al Therapy Treat	monto							т а т	CONTI	DINIC	(C 'C)
		re - Par		incii(8						10	TAL 1,774	CCNH 1,774	RHNS	(Specify)
			lusive of Part B)								*************	1,774		
			e Treatments								416	416		
		torative	Treatments				***************************************				1,868	1,868		
	Other										3,296	3,296		
			Therapy Treati							***************************************	7,354	7,354		~~~
		Speech ire - Par	Therapy Treatm	ents										
			ь Iusive of Part B)								327	327		
Б.			e Treatments								38	38		
			Treatments								90	90		
C.	Other										411	411		
D.	Total S	peech T	Therapy Treatm	ents							866	866		
9. Total Nu	mber of	Occupa	itional Therapy	Treatr	nents									
		re - Par							,		1,882	1,882		
В.			lusive of Part B) e Treatments	ı										
			Treatments			*******				<u> </u>	929	929		
C.	Other										1,521 4,102	1,521 4,102		
		Эссираt	ional Therapy T	reatn	nents				****		8,434	8,434		

### **Annual Report of Long-Term Care Facility**

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Report of Expenditures - Salaries & Wages

Report of Ex	<del>^</del>	- Dalain			T	
Name of Facility	License No.		Report for Year	Ended	Page	of
Meriden Care Center, LLC	2448		9/30/2019		10	37
Are time records maintained by all individuals receiving cor	nnensation?	•	Yes	0	No	
	8					
	3	1	Total Cost a	na Hours	I	<u> </u>
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*	CCNH	HOUIS	KHINS	FIGUIS	(Specify)	Hours
Operators/Owners (Complete also Sec. I						
of Schedule A1)		***************	************************			
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	165,134	2,086				
Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
Other Administrative Salaries (telephone						
operator, clerks, receptionists, etc.)	205,311	9,650				
5. Dietary Service						
a. Head Dietitian	9,331	207				
b. Food Service Supervisor c. Dietary Workers	56,482 524,774					
6. Housekeeping Service	324,774	29,892				
a. Head Housekeeper		***************************************				<b> </b>
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	59,314					
b. Other Maintenance Workers	42,040	2,124				
8. Laundry Service						
a. Supervisor					<b></b>	
b. Other Laundry Workers     9. Barber and Beautician Services						1
10. Protective Services			<u> </u>			
11. Accounting Services						
a. Head Accountant	800000000000000000000000000000000000000			***************************************	***************************************	
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	212,658	3,747				
b. RN						
1. Direct Care	473,642					
2. Administrative** c. LPN	319,888	8,529				***************************************
1. Direct Care	1,468,493	48,229				
2. Administrative**	1,400,493	40,229				
d. Aides and Attendants	2,306,709	133,518				
e. Physical Therapists						·
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	189,200	9,284				
i. Physicians						
Medical Director     Utilization Review						
3. Resident Care***		<u> </u>		ļ		<b></b>
4. Other (Specify)	-		<u> </u>			
	P		T	<b> </b>	**************************************	1
j. Dentists						
k. Pharmacists						
1. Podiatrists						
m. Social Workers/Case Management	204,871	5,899				
n. Marketing o. Other (Specify)	1					
See Attached Schedule	34,205	2,069				
A-13. Total Salary Expenditures	6,272,054				<del> </del>	
La L	1 0,212,034	207,014	1	J	1	<u> </u>

<sup>\*</sup> Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

<sup>\*\*</sup> Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

<sup>\*\*\*</sup> This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

### Schedule of Other Salaries and Wages (Page 10)

	CC	NH	RH	INS	(Spe	cify)
Position	S	Hours	\$	Hours	\$	Hours
UNIT SECRETARIES SALARIES	\$ 23,643	1,356			\$ -	
MEDICAL RECORDS SALARIES	\$				\$ -	
CENTRAL SUPPLY SALARIES	\$ 10,562	713			\$ -	3 - 1 - 1
RESPIRATORY THERAPY SALARIES	\$ -				\$ -	_
						griphica telic
					g to tenegrate	
			6 1.5 6 6 6			
Total	\$ 34,205	2,069	•		\$	
LUM	34,203	2,009	<u>.</u> . Фидо в и по 7 года	1	Ι Ψ	<u> 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 </u>

Schedule of Other Fees (Page 13)

		CC	NH	RH	INS	(Spe	cify)
Service		\$	Hours	\$	Hours	\$	Hours
MEDICAL RECORDS CONTRACT SERVICE	\$	3,669	an a			\$ -	
ADMISSIONS C/S LABOR	\$	53,125	1,113			\$ -	<b>.</b> - 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
CENTRAL SUPPLY CONTRACT SERVICE	\$	1,859	55			\$ -	
ADMINISTRATIVE CONTRACT SERVICE LABOR	\$	115,003	3,300			\$	
RESPIRATORY THERAPY CONTRACT SERVICES	\$	11	0			\$	
PHYSICAL THERAPY C/S MEDICIAD	\$	37,198	617			\$ -	
SPEECH THERAPY C/S Medicaid	\$	4,013	64			\$ -	
OCCUPATIONAL THERAPY C/S MEDICIAD	\$	39,180	643			\$ -	
	3.5						
Total	\$	254,058	5,793	\$ -		\$ -	

State of Connecticut Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005

# Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

Nome of Bootlity		7	ASSISTANT	t Administra Figure Mo	Some No.   Demonstrations and Other Related Fattles:	r Kelak	ver Erded		Dogo	با
Manie of Facility				Licelise 100.		nepolition	repoit ior rear cauca		Гаge - 1	0 <u>1</u>
Menden Care Center, LLA				7448		9/30/2019			11	3/
		Salary Paid	ď	:						***************************************
				rringe Benefits and/or Other		Total	Line Where	,	Total	·
Name	CCNH	REINS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Clauned on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
							411			
* No allowance for salaries will be considered unless full information is provided. Use additional sheets if required	be consider	ed unless fi	Ill informatic	n is provided Usa	additional sheets if re	squired.				

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all employment worked during the cost year.

State of Connecticut Annual Report of Long-Term Care Facility CSP-12 Rev. 10/2005

# Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

		Į	Assistan	t Aummistra	Assistant Administrators and Other Related Farties"	Kelaled	rarues			
Name of Facility (as licensed)				License No.		Report for Year Ended	ear Ended		Page	Jo
Meriden Care Center, LLC				2448		9/30/2019			12	37
		Salary Paid	70							
				Fringe Benefits and/or Other			Line Where		Total	
Name	CCNH	RHNS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***								The same of the sa		
				same as employees less						
Raymond Hackling	165,134			union funds	Administrator	2,086 A2	42			
And the state of t				same as						
				employees less						
				union funds	Administrator		A2			
				same as						
				employees less					•	
				union funds	Administrator	,	A2_			
Section IV - Assistant Administrators									***************************************	
					ot to the section of					
								:		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	, .	2 1 1	. 11 2		4, 4, 4, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,					

\*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all other employment worked during the cost year.

<sup>\*\*\*</sup> If more than one Administrator is reported, include dates of employment for each.

### **Annual Report of Long-Term Care Facility**

CSP-13 Rev. 9/2002

**B.** Report of Expenditures - Professional Fees

Name of Facility	License No.		Report for Y		Page	of
Meriden Care Center, LLC	244	18	9/30/2019		13	37
· ·			Total Cost a	and Hours		
			,			
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian	5,288	118		•		
2. Dentist						
3. Pharmacist	30,516	416				
4. Podiatrist	*******************************	********************	************************	***********************	000000000000000000000000000000000000000	400000000000000000000000000000000000000
5. Physical Therapy						
a. Resident Care	64,262	489				
b. Other						
6. Social Worker	76,294	1,368				
7. Recreation Worker	18,953	35+Cable		***************************************	***************************************	35+Cable
8. Physicians						
a. Medical Director (entire facility)	36,000	257		***************************************		
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
Infection Control Committee     (Quarterly meetings)						
2 Pharmaceutical Committee						
(Quarterly meetings)						
3. Staff Development Committee						
(Once annually)		***************************************				
e. Other (Specify)						
Physician Care Contract Services	18,042	69				
9. Speech Therapist						
a. Resident Care	23,470	305				
b. Other						
10. Occupational Therapist	76.000					
a. Resident Care b. Other	76,830	840				
11. Nurses and aides and attendants						
a. RN  1. Direct Care	20.402	400				
2. Administrative***	29,683	(793)		1		-
b. LPN	(29,675)	(783)				
1. Direct Care	2 101	77				
2. Administrative***	3,291	76				
c. Aides						<u> </u>
d. Other						
12. Other (Specify)						1
See Attached Schedule	254,058	5,793				
B-13 Total Fees Paid in Lieu of Salaries	607,011	9,356				
* Do not include in this section management consultants or services which			12 and summarted has	I and information	I D 17	<u> </u>

<sup>\*</sup> Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

<sup>\*\*</sup> This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

<sup>\*\*\*</sup> Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

### Report of Expenditures Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\*

Name of Facility	License No.		Report for	Year Ended	Page	of
Meriden Care Center, LLC	2448		9/30/2019	•	14	37
Name & Address of Individual	Full Explanation of Service		* to Owners, ors, Officers		nation of Rela	tionship
ivalie & Address of Individual	run Explanation of Service	Yes	No No	Expia	nation of Itola	nonsinp
Tocuhpoints Therapy	Therapy	0	0	Common Own	ership	
Chelsea Place, Chestnut Point, Kettle Brook, Trinity Hill, Wintonbury, Farmington, Silver	Shared Employees	0	0	Common Own	ership	
Pharm Scripts	Pharmacy Contract	0	0			
Guardian Consulting Srv	Pharmacy Consulting	0	0			
Healthdrive Physician Services	Audiology, Dental and Podiatry	0	0			
Ready Nurse, Nurse Network	Nursing pool (RN, LPN,CNA)	0	0			
IPC Hospitalists	Medical Director	0	0			
		0	0			
		0	0			
		0	•			
		0	0			
		0	0			
		0	0			3 - 1 - 2 - 11 - 11 - 11 - 11 - 11 - 11
		0	0			
		0	0			
		0	0			
		0	•			
		0	0		-	
		0	0			
		0	•	3		
		0	0			
		0	0			

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

### C. Expenditures Other Than Salaries - Administrative and General

Name	of Facility L	icense No.	Report for Y	ear Ended	Page	of
	en Care Center, LLC	2448	9/30/2019		15	37
	Item		Total	CCNH	RHNS	(Specify)
1. Ad	ministrative and General					
a.	Employee Health & Welfare Benefits					
	1. Workmen's Compensation	9	285,726	285,726		
	2. Disability Insurance	Q S	5			
	3. Unemployment Insurance	3	S .			
	4. Social Security (F.I.C.A.)	9	537,723	537,723		
	5. Health Insurance	9	1,118,480	1,118,480		
	6. Life Insurance (employees only)					
	(not-owners and not-operators)	9	S		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	7. Pensions (Non-Discriminatory)	9	369,972	369,972		
	(not-owners and not-operators)					
	8. Uniform Allowance	9	S			
	9. Other ( <i>Specify</i> )	9	45,619	45,619		, , , , , , , , , , , , , , , , , , , ,
	See Attached Schedule					
b.	Personal Retirement Plans, Pensions, and	9	5			
	Profit Sharing Plans for Owners and					
	Operators (Discriminatory)*					
C.	Bad Debts*	S	34,600	34,600		
d.	Accounting and Auditing	4	8,859	8,859		
e.	Legal (Services should be fully described o	n Page 7)	10,435	10,435		
f.	Insurance on Lives of Owners and		5			
	Operators (Specify)*					
g.	Office Supplies	9	23,002	23,002		
h.	Telephone and Cellular Phones					
	1. Telephone & Pagers	9	26,373	26,373	• 0000000000000000000000000000000000000	
	2. Cellular Phones	(	1,633	1,633		
i.	Appraisal (Specify purpose and		B			
	attach copy)*					
j.	Corporation Business Taxes (franchise tax	)	250	250		
k.	Other Taxes (Not related to property - See	Page 22)				
	1. Income*		<b>6</b>			z-meneronani (1800/1800)
	2. Other (Specify)		Б			
	See Attached Schedule					
	3. Resident Day User Fee		1,195,407	1,195,407		
Subtot	al		3,658,078	3,658,078		
	ility about dealf digathers the assessment Dec. 20 - 6					1

<sup>\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

### \*\*\* DO NOT Include Holiday Parties / Awards / Gifts to Staff

Attachment Page 15

### **Schedule of Other Employee Benefits**

Description	CCNH	RHNS	(Specify)
UNION TRAINING	\$ 45,619		\$ -
Total	\$ 45,619	\$ -	\$ -

### **Schedule of Other Taxes**

Description	CCNH	RHNS	(Specify)
INTERNET EXPENSES	\$ -		\$ -
Total	\$ -	\$ -	\$ -

### C. Expenditures Other Than Salaries (cont'd) - Administrative and General

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Meriden Care Center, LLC	2448		9/30/2019		16	37
Item			Total	CCNH	RHNS	(Specify)
	ls Brought Forwai	rd:	3,658,078	3,658,078		***************************************
1. Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$	2,186	2,186	·	
<ol><li>Gifts to Staff and Residents</li></ol>		\$	162	162		
4. Employee Travel		\$	4,331	4,331		
<ol><li>Education Expenses Related to Seminars and</li></ol>	l Conventions	\$	7,035	7,035		
6. Automobile Expense (not purchase or depre	eciation)	\$				
7. Other (Specify)		\$	199	199		
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expenses	')	\$	14,175	14,175		
2. Advertising Telephone Directory (all such ex	kpenses )***	\$				
3. Advertising Other (Specify)***		\$	27,890	27,890		
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service is	s supplied	\$				
directly and not by contract or fee for service						
7. Postage	<u> </u>	\$	4,196	4,196		
* 8. Dues and Membership Fees to Professional		\$	10,754	10,754		
Associations (Specify)			,	,		
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-A	Allowable Org.***	\$				
9. Subscriptions		\$				
10. Contributions***	· · · · · · · · · · · · · · · · · · ·	\$	360	360		
See Attached Schedule						
11. Services Provided by Contract (Specify and	Complete	\$	128,875	128,875		<u> </u>
Schedule C-2, Page 21 for each firm or indi	^	•				
12. Administrative Management Services**		\$	393,874	393,874		
13. Other ( <i>Specify</i> )		\$	21,003	21,003		
See Attached Schedule		~	,			
C-14 Total Administrative & General Expenditures		\$	4,273,119	4,273,119		

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

### Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
MEALS	\$ 199		\$
		gritalitan k	naciely gr
Total Other Travel and Entertainment	\$ 199	\$ -	s -

### Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
COMMUNICATIONS SPECIAL EVENTS	\$ 27,890		8
			, 1,500 / 100 / 10
Total Other Advertising	\$ 27,890	\$ -	\$

### Schedule of Dues

Description	CCNH	RHNS	(Specify)
ALTCFM			
CAHCF Dues	\$ 10,594		\$
OTHER DUES	\$ 160	<b>电影电影电影电影</b> 电影	\$
	and hip rel		
	un inggan		
Total Dues	\$ 10,754	\$	\$ -

### Schedule of Contributions

Description	CCNH	RHNS	(Specify)
CONTRIBUTIONS	\$ 360		\$
	ereja i en jega		
		da esta esta esta esta esta esta esta est	
Total Contributions	\$ 360	\$ -	\$

### Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)	
SOCIAL SERVICE SUPPLIES	\$ 247		\$ -	
SOC SVC MINOR EQUIPMENT	\$ -		S	
ADMINISTRATIVE MINOR EQUIPMENT	\$ 127		\$ -	
EMPLOYEE RELATIONS	\$ 3,417		\$	
EMPLOYEE RELATIONS-OTHER	\$ 182		\$ -	
PERMITS & LICENSES	\$ 1,815		\$ +	
VOLUNTEER EXPENSE	\$		\$	
BANK PEES	\$ 12,954		\$	
CMS REVISIT USER FEES	\$		\$ -	
PENALTIES	\$ -		\$	
LATE FEES	\$ 394		\$ -	
INTERNET EXPENSES	\$ 1,868		\$ -	
Rounding	\$ 0			
Total Other Administrative and General	\$ 21,003	\$	S	

### Schedule C-1 - Management Services\*

Name of Facility  Moridan Cara Center, LLC	License No. 2448	Report for Year Ended 9/30/2019	Page of 17   37
Meriden Care Center, LLC	<u> </u>	9/30/2019 	1/   3/
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
iCare Management, LLC/iCare Health Management, LLC	393,874	Management of financial statements, A/R, A/P, Payroll, Financial Accounting and Management, Clinical	Pg 16 M12
iCare Management, LLC/iCare Health Management, LLC	222,408	MANAGEMENT FEES- DIRECT CARE	Pg 20 j
iCare Management, LLC/iCare Health Management, LLC	31,132	MANAGEMENT FEES- INDIRECT CARE	Pg 20 j

<sup>\*</sup> In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

### **Annual Report of Long-Term Care Facility**

CSP-18 Rev. 9/2018

### C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs (See Note on Page 5)

) T				rage 5)	ln . c x	773 1 1	I D	
Name of Facility			ense	No.	Report for Y		Page	of
Mer	iden Care Center, LLC			2448	9/30/2019	)	18	37
	Item			Total	CCNH	RHNS	(Sp	ecify)
2.	Dietary							
	a. In-House Preparation & Service							
	1. Raw Food		\$	368,745	368,745			
	2. Non-Food Supplies		\$	42,104	42,104			
	3. Other (Specify)		\$	16,717	16,717			
	DIETARY SUPPLEMENTS							
	b. Purchased Services (by contract other		\$	3,426	3,426			
	than through Management Services)							
	(Complete Schedule C-2 att. Page 21)							
	c. Other (Specify)		\$	8,271	8,271			
	DIETARY MINOR EQUIPMENT							
2D.	Total Dietary Expenditures $(2a + b + c + d)$		\$	439,262	439,262			
2E. F. G.	Dietary Questionnaire  Resident Meals: Total no. of meals served per d  Is cost of employee meals included in 2D?	lay:* O Ye	s	Total 467 <b>⊙</b>	CCNH 467 No	RHNS	(Sp	ecify)
H.	Did you receive revenue from employees?	O Ye	s	•	No	If yes, specify amt.		
I.	Where is the revenue received reported in the Co	ost Re	port'	? (Page/Line It	tem)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	O Ye	S	•	No	If yes, specify cost.		
K.	Is any revenue collected from these people?	O Ye	s	•	No	If yes, specify amt.		
L.	Where is the revenue received reported in the Co	ost Re	port	? (Page/Line It	tem)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	O Ye	s	•	No	If yes, specify cost.		
N.	Is any revenue collected from employees?	O Ye	s	0	No	If yes, specify amt.		
O.	Where is the revenue received reported in the Co	ost Re	port	? (Page/Line I	tem)			
				<u> </u>				

<sup>\*</sup> Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

### C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs (See Note on Page 5)

Name of Facility Meriden Care Center, LLC			No. 2448	Report for Year Ended 9/30/2019		Page of 19   37
ivieri	den Care Center, ELC		Z440	7/30/2019		
	Item		Total	CCNH	RHNS	(Specify)
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items	Lbs.	744	744		
	washed, ironed, and/or processed.***	Truit. w	'''	, , , ,		
	Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.				
	processed.***	Amt. \$				
	3. Personal clothing of residents	Lbs.				
	washed, ironed, and/or processed.***	Amt. \$				
	4. Repair and/or purchase of linens.***	Lbs.				
		Amt. \$	<del>-</del>			
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	416,509	416,509		
275	c. Other (Specify)  LAUNDRY MINOR EQUIPMENT	\$				
3D. 3E.	Total Laundry Expenditures (3a + b + c) Laundry Questionnaire	\$	417,550	417,550	1	
F.		) Yes	•	No	If yes, specify cost.	
G.	Did you receive revenue from employees?	) Yes	•	No	If yes, specify amt.	
Η.	Where is the revenue received reported in the Cost	Report?		(Page/Line	tem)	
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	) Yes	0	No	If yes, specify cost.	
J.	Did you receive revenue from these people?	) Yes	•	No	If yes, specify amt.	
K.	Where is the revenue received reported in the Cost	Report?		(Page/Line	e Item)	

<sup>\*</sup> Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4. All allocations should add to total recorded in 3D.

<sup>\*\*\*</sup> Pounds of Laundry only required for multi-level facilities.

### C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Rep	ort for Year E	nded	Page	of
Meriden Care Center, LLC	2448		9/30/2019		20	37
Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced					
a. In-House Care	by Personnel					
1. Supplies - Cleaning (Mops,	Amt,	\$	32,931	32,931		
pails, brooms, etc.)						
b. Purchased Services (by contract	other Sq. Ft. Serviced					
than through Management Serv	nices) by Personnel					
(Complete Schedule C-2 att.	Amt.	\$	458,379	458,379		
Page 21)						
C. Other (Specify)		\$				
HOUSEKEEPING MINOR	EQUIPMENT					
4D. Total Housekeeping Expenditures	(4a+b+c)	\$	491,309	491,309		
5. Resident Care (Supplies)**	<del> </del>					
a. Prescription Drugs***						
1. Own Pharmacy		\$		***************************************		
2. Purchased from		\$	285,107	285,107		
PHARMACY						
b. Medicine Cabinet Drugs		\$	4,552	4,552		
c. Medical and Therapeutic Supplie	es	\$	124,600	124,600		
d. Ambulance/Limousine***		\$	7,962	7,962		
e. Oxygen						
1. For Emergency Use		\$	4,730	4,730		
2. Other***		\$				
f. X-rays and Related Radiological		\$	3,446	3,446		
Procedures***						
g. Dental (Not dentists who should	be included under	\$				
salaries or fees)						
h. Laboratory***		\$	12,600	12,600		
i. Recreation		\$				
j. Direct Management Services*		\$				
k. Indirect Management Services*		\$				
1. Other (Specify)****		\$	329,836	329,836		
See Attached Schedule						
5M. Total Resident Care Expenditures	(5a - 5j)	\$	772,833	772,833		

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*</sup> Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

### **Schedule of Other Resident Care**

Description	CCNH	RHNS	(Specify)
NURSING ADMIN SUPPLIES	\$ 111		\$ -
NURSING MINOR EQUIP	\$ 5,238		\$ -
MEDICAL RECORDS SUPPLIES	\$ 1,569		5
MEDICAL RECORDS MINOR EQUIPMENT	\$ -		\$ -
MANAGEMENT ALLOCATIONS - DIRECT	\$ 222,408		\$ -
NON-COVERED PPS DR. VISITS	\$ 7,278		\$ -
RESIDENT CARE SUPPLIES	\$ -		\$ -
CENTRAL SUPPLY MINOR EQUIPMENT	\$ 11,638		- \$
PERSONAL CARE SUPPLIES	\$ 467		\$ -
INCONTINENCY SUPPLIES	\$ 817		\$ -
VACCINE RESIDENTS	\$ (3,898)		\$
PATIENT SPECIAL NEEDS	\$ -		\$ -
PHYSICAL THERAPY SUPPLIES	\$ -		\$ -
PHYSICAL THERAPY EQUIPMENT RENT	\$ -		\$ -
PHYSICAL THERAPY MINOR EQUIPMENT	\$ -		\$ -
OCCUPATIONAL THERAPY SUPPLIES	\$ -		s -
OCCUPATIONAL THERAPY EQUIP RENTAL	\$ -		\$ -
OCCUPATIONAL THERAPY MINOR EQUIP	\$ -		\$ -
SPEECH THERAPY SUPPLIES	\$ -		\$ _
SPEECH THERAPY EQUIPMENT RENT	\$ -		\$ -
SPEECH THERAPY MINOR EQUIPMENT	\$		\$ -
RENTALS FOR NURSING EQUIPMENT NON BILLABLE	\$ 24,206		\$ -
EQUIPMENT RENTAL: AIDS UNIT	\$ -		\$ -
PEN THERAPY SUPPLIES - NOT BILLABLE TO PART B	\$ -		\$ -
PEN THERAPY FOOD NOT BILLABLE TO PART B	8		\$
HI LOW BED RENTAL & MATTRESSES	\$ -		\$ -
IV THERAPY SUPPLIES	\$ 7,765		\$ -
IV THERAPY CONTRACT SERVICE	\$ -		\$ -
MEDICAL WASTE CONTRACT SERVICE	\$ 2,138		\$ -
ACTIVITIES SUPPLIES	\$ 13,165		\$ -
ACTIVITIES MINOR EQUIPMENT	\$ 439		\$ -
MANAGEMENT ALLOCATION - INDIRECT	\$ 31,132		\$ -
ADMISSIONS SUPPLIES	\$ -		\$ -
MEDICAL COURIER SERVICES FOR SPECIAL PRESCRIPTIONS	\$ -		\$ -
STRIKE COSTS NON REIMBURSABLE	\$ 5,364		\$ -
Total Other Resident Care	\$ 329,836	\$	\$ -

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## Schedule C-2 - Individuals or Firms Providing Services by Contract \* Report of Expenditures

Name of Individual or  Company  Address  Company  3220 Tillman Drive,  Health Services Group Health Services Group/Unitex Textile Rental Services Group/Unitex  Bensalem, PA 19020  Eagle Elevator  Bioserve, Inc.  Brightview Landscaping/Amaya Landscaping  CWPM  American Health Tech P.O. Box 9001006, Automatic Data Processing National Datacare Corp  Printe Care Technologuy services  Prioticy Express  Prioticy Express		2448	9/30/2019				Page 21	of 37
me of Individual or  Company  Address  3220 Tillman Drive, Bensalem, PA 19020 Bervices Group/Unitex Services Group/Unitex Services Bensalem, PA 19020 Bensalem, PA 19020 Bensalem, PA 19020 Bensalem, PA 19020 Evator  In Health Tech Bensalem, PA 19020 Bensalem, PA 19020 Bensalem, PA 19020 Bensalem, PA 19020 For Data Processing For Data Processing For Data Processing For Bensalem, PA 19020 For Bensalem, PA 19	Related ** to Owners,	SIS,		[	/ to / [s	Total Cont (Dags Daf ***		
me of Individual or  Company  3220 Tillman Drive, Bensalem, PA 19020 6 P.O. Box 9001006, Gew Landscaping/Amaya ping  In Health Tech  Datacare Corp  Datacare Corp  Express  Express	Operators, Orno	21		01	idi Cost	rage ner		Ī
ervices Group Services Group Services Group Services Group/Unitex Services Group/Unitex Services Group/Unitex Services S	No.	Explanation of Deletionshin	Full Explanation of		punic	(Crowify)	<u>ا</u>	.; -
evator  services Group/Unitex Sental Services Sental Services Sental Services Sental Services Sental Services Bensalem, PA 19020  evator  i. Inc.  ew Landscaping/Amaya ping  h. Health Tech  ping  P.O. Box 9001006,  itc Data Processing  Louisville, KY 40290  Datacare Corp  are Technologuy services  Express	å c	VENT	Housekeening Services		CATA	(Specify)		4
evator  Inc.  ew Landscaping/Amaya  ping  n HealthTech  The Data Processing  Datacare Corp  are Technologuy services  Express	0	VENDOR	Laundry Services	416,509			-	38
w Landscaping/Amaya ping  n HealthTech ic Data Processing Datacare Corp  are Technologuy services  Express	0	VENDOR	Elevator Contract	9,189			22	6F
ew Landscaping/Amaya ping  n HealthTech lic Data Processing  Datacare Corp  are Technologuy services  Express	0	VENDOR	Medical Waste	2,138			72	6F
n Health Tech P.O. Box 9001006, lic Data Processing Louisville, KY 40290  Datacare Corp  are Technologuy services  Express	0	VENDOR	Snow Removal/Landscaping	26,882			22 (	6F
Focessing P.O. Box 9001006, Processing Louisville, KY 40290 re Corp nologuy services	0	VENDOR	Trash removal	46,858			22	6F
P.O. Box 9001006, Processing Louisville, KY 40290 re Corp nologuy services	0	VENDOR	Software Maintenance Contract	12,713			16]	MII
re Corp nologuy services	0	VENDOR	Payroll Services	49,593			16	M11
nologuy services	0	VENDOR	Resident Trust Software	3,791			16	M11
	0	VENDOR	Computer Consulting Services	31,810			16	M11
	0	VENDOR	Courier Services	3,345			16	M11
Point Right Inc O	0	VENDOR	Nursing Software	4,680			16	M11
0	0	VENDOR					22 6F	į,
0	0	VENDOR						

<sup>\*</sup> List all contracted services over \$10,000. Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

### C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

1	i	License No.	Report for Y	ear Ended		Page	of
Mei	riden Care Center, LLC	2448	9/30/2019			22	37
	Item		Total	CCNH	RHNS	(Cm	a aife.)
6.	Maintenance & Operation of Plant		TOtal	CUNH	KIIIVS	(Sp	ecify)
υ.	-	ф	50 001	50.001			
	a. Repairs & Maintenance	\$	58,231	58,231			
	b. Heat	\$	36,673	36,673			
	c. Light & Power	\$	125,594	125,594	**************************************		-
	d. Water	\$	90,496	90,496			
	e. Equipment Lease (Provide detail on po		47,867	47,867			
	f. Other (itemize)	\$	118,657	118,657			
	See Attached Schedule						
6g.	Total Maint. & Operating Expense (6a -	·	477,517	477,517			
7.	Depreciation (complete schedule page 23*	*)					
	a. Land Improvements	\$		:			
	b. Building & Building Improvements	\$	23,223	23,223			
	c. Non-Movable Equipment	\$					
	d. Movable Equipment	\$	51,459	51,459			
*7e	Total Depreciation Costs $(7a + b + c + d)$	) \$	74,682	74,682			
8.	Amortization (Complete att. Schedule Pag	ge 24*)					
	a. Organization Expense	\$					
	b. Mortgage Expense	\$					
	c. Leasehold Improvements	\$	50,135	50,135			•••
	d. Other (Specify)	\$		,	· · · · · · · · · · · · · · · · · · ·		
*8e.	Total Amortization Costs (8a+b+c+d		50,135	50,135			
9.	Rental payments on leased real property le	SS					
	real estate taxes included in item 10b	\$	585,265	585,265			
10.	Property Taxes	· · · · · · · · · · · · · · · · · · ·					
	a. Real estate taxes paid by owner	\$					
	b. Real estate taxes paid by lessor	\$	153,391	153,391			
	c. Personal property taxes	\$	13,392	13,392			
11.	Total Property Expenses $(7e + 8e + 9 + 1)$		876,865	876,865			

<sup>\*</sup> Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

### Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
PLANT SUPPLIES	\$ 8,541		\$ -
PLANT CONTRACT SERVICE LABOR	\$		\$ -
ELEVATOR CONTRACT SERVICE	\$ 9,189		\$ -
FIRE/SPRINKLER CONTRACT SERVICE	\$ 8,937		\$ -
LANDSCAPING CONTRACT SERVICE	\$ 9,015		\$ -
SNOW REMOVAL CONTRACT SERVICE	\$ 17,867		\$ -
TRASH REMOVAL CONTRACT SERVICE	\$ 46,858		\$ -
HVAC CONTRACT SERVICE	\$		\$ -
SECURITY CONTRACT SERVICE	<b>S</b>		\$ -
PLANT CONTRACT SERVICE OTHER	\$ 8,940		\$ -
PLANT MINOR EQUIPMENT	\$ 9,311		\$ -
RENT AUTO	- \$		\$ -
RENT EQUIPMENT	<b>S</b>		S -
RENT OTHER	<b>S</b> .		\$ -
Total Other Repairs and Maintenance	\$ 118,657	s -	\$ -

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Depreciation Schedule

Name of Facility			License No.			Report for Year Ended	uded		Page	of
Meriden Care Center, LLC			2448	œ		9/30/2019			23	37
			Historical			Accumulated				
			Cost	Less		Depreciation to	Method of			
:			Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Property Item			Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
A. Land Improvements										
<ol> <li>Acquired prior to this report period</li> </ol>					•••					
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	ch schedule)									
A-4. Subtotal										
B. Building and Building Improvements	797A-14-14-14-14-14-14-14-14-14-14-14-14-14-									
1. Acquired prior to this report period		•	416,163		416.163	77.347			23 223	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	ch schedule)			7						
B-4. Subtotal										23 223
C. Non-Movable Equipment										
1. Acquired prior to this report period										
2. Disposals (attach schedule)	MINITED TO THE PERSON OF THE P									
3. Acquired during this report period (attach schedule)	sh schedule)									
C-4. Subtotal										
	Is a mileage		Lietonical			,				
	<u>~</u>	Date of Acquisition	Cost	Less		Depreciation to	Method of			
	2	Veor	Exclusive of	Salvage	Cost to Be	Beginning of	Computing	Useful	Depreciation	Į.
D. Movable Equipment	2	3	Name of the last	) and	Lepiccialed	i cai s Opciations	Depreciation	LIE	IOI IIIIS I CAI	LOIAIS
1. Motor Vehicles (Specify name, model										
and year of each vehicle)										
a. Van Repair: Hillside Automotive Celx	×									
. <del>.</del> .										
C.										
d.										
2. Movable Equipment										
a. Acquired prior to this report period			812,504		812,504	626,342			46.183	
b. Disposals (attach schedule)										
c. Acquired during this report period										
(attach schedule)			78,847						5.277	
D-3. Subtotal										51,459
E. Total Depreciation									1	74,682
THE TRANSPORT TRANSPORT TO THE TRANSPORT						***************************************		MANAGORA CONTRACTOR CO	E	-

Heaful

### Schedule of Land Improvements Acquired during this report period

		Oseiui	
Description of Item	Cost	Life	Depreciation
Land Improvements	\$ -		\$ -
Land Improvements	\$		\$ -
	Description of Item  Land Improvements  Land Improvements	Land Improvements 3	Description of Item Cost Life  Land Improvements \$

<sup>\*</sup>Ties to Page 23, Line A3

### Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	<i>a</i> .	Useful	To 1 11
Additions:	Description of Item	Cost	Life	Depreciation
0.4.0				
	Building Improvements	\$ -		\$ -
Deletions:				
otal deletions for	Building Improvements	s -		\$ -
ATT : D			11 (1986) 17301 136 53 53	

<sup>\*</sup>Ties to Page 23, Line B3

### Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	D. J. C. AV.		Useful	
Additions;	Description of Item	Cost	Life	Depreciation
	Non-Movable Equipment	\$ -		\$ -
Deletions:				
Total deletions for	 Non-Movable Equipment			
Torut deterious 101 3	ann-taineanne refutbuteut	\$ -		\$

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Ties to Page 23, Line B2

<sup>\*\*</sup>Ties to Page 23, Line C2

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				opromision
11/30/2018	Heat pumps: Direct Supply	\$ 3,965	120	\$ 330
3/27/2019	Medline Beds and Mattresses	\$ 30,173	60	\$ 3,017
3/25/2019	Medline: Bariafric Charles	\$ 4,538	120	\$ 227
2/25/2019	Washing Machine: Daniels Equipment	\$ 11,433	120	\$ 667
6/19/2019	Electric Beds & Mattresses Medline	\$ 16,252	60	\$ 813
8/31/2019	Desktops/Monitors: Primecare	\$ 8,009	36	\$ 222
9/30/2019	Wifilemts: Primecare Technologies	\$ 4,478	36	<b>.</b> 13 5 5 5 5 5 5
				antileză (
Total additions for	Movable Equipment	\$ 78,847		\$ 5,277
Deletions:				
				Section (
			ANY BELLEVIE	
Total deletions for	Movable Equipment	\$ -		\$ -

<sup>\*</sup>Ties to Page 23, Line D2c

### Schedule of Leasehold Improvements Acquired during this report period

Annuisition Date	D. J. H. are		Useful	
Acquisition Date Additions:	Description of Item	Cost	Life	Depreciation
11/30/2018	Replemt doors per DPH life Safety Survey Sahar	\$ 7,510	180	\$ 417
10/30/2018	Toilet Replaced: Multiple Vendors	\$ 21,527	180	1011 111 111
5/18/2018	Concrete Wall; Sahar Shamlom	\$ 7,600	240	\$ 507
2/20/2018	Ventilation Expansion: Climatech	\$ 9,034	180	
1/23/2019	Tree Removal:Amaya	\$ 2,765		\$ 184
7/8/2019	Rehab Gym AC unit Climatech	\$ 8,455		<b>\$</b> 94
7/15/2019	Facia Rplcmt - Target 10 Construction	\$ 2,978	300	\$ 20
8/12/2019	Concrete Repair: Target 10 Construction	\$ 2,978	240	<b>\$</b> 12
	Leasehold Improvement	\$ 62,847		\$ 3,504
Deletions:				
Total deletions for	Leasehold Improvement	\$ -		\$ -

<sup>\*</sup>Ties to Page 24, Line C3

<sup>\*\*</sup>Ties to Page 23, Line D2b

<sup>\*\*</sup>Ties to Page 24, Line C2

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### Amortization Schedule\*

Name of Facility	WARANAGATA	License No.		Report for Year Ended	r Ended	Page	Jo
Meriden Care Center, LLC		2448	18	9/30/2019		24	37
				Accumulated			
	Date of			Amort. to			
	Acquisition			Beginning of	Basis for		
		Length of	Cost to Be	Year's	Computing	Rate	
Item	Month  Year	Amortization	Amortized	Operations	Amortization**	% for This Year	r Totals
A. Organization Expense	•						
2.							
3.				A CONTRACTOR OF THE CONTRACTOR	in the second se		
A-4. Subtotal							
B. Mortgage Expense							
F(	4.1						
2.							1
3.					To the state of th		·
B-4. Subtotal							
C. Leasehold Improvements and Other	+						
1. Acquired prior to this report period			692,068	379,433		46,631	
2. Disposals (attach schedule)							T.
3. Acquired during this report period				***************************************			
(attach schedule)			62,847			3,504	
C-4. Subtotal							50,135
D. Total Amortization							50,135
A CA							

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

## C. Expenditures Other Than Salaries (cont'd) - Property Questionnaire

Name of Facility	License No.	Report for Year End	Page of		
Meriden Care Center, LLC	2448	9/30/2019			25   37
11. Property Questionnaire					
Part A					
Is the property either owned by the	- Facility				If "Yes," complete Part B.
or leased from a Related Party?*	O	Yes	•	NO	If "No," complete Part C.
*If any owner or operator of this facil	lity is related by family ma	rriage ownership ability	to control or		11 110, 1011p1110 1 0110 01
business association to any person or					
related party transaction.	-	·			
Description		Total	•		
Date Land Purchased		12/01/03			
2. Date Structure Completed	CD 1				
3. If <b>NOT</b> Original Owner, Date	of Purchase	10/01/02			
<ul><li>4. Date of Initial Licensure</li><li>5. Total Licensed Bed Capacity</li></ul>		12/01/03			
6. Square Footage		159			
7. Acquisition Cost		65,790			
a. Land					
b. Building					
Part B - Owner and Related Par	rties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing		1011110116460	2110 17107 15450	514 1110115450	10111101164
a. Type of Financing (e.g., fix	red, variable)				
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Y	<i>Y</i> ear				
d. Term of Mortgage (numbe	r of years)				
e. Amount of Principal Borro					
f. Principal balance outstand	ing as of				
Complete if Mortgage was F					
During Current Cost Yea		,			
g. Type of Financing (e.g., fix	(ed, variable)			•	
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (numbe k. Amount of Principal Borro				***************************************	
Amount of Principal Bond     Principal Outstanding on N					
Part C - Arms-Length Lease		Improvements O-1	7		
Name and Address of Lessor				Torm of Lacas	Annual Amount of Lease
Summit Meriden, LLC		reet, Meriden, CT	08/09/17	Term of Lease	\$598,500 yr 1
Summit Worldon, LLC	33 KUy 30	eet, Menden, C1	00/09/17		9396,300 yr I

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

# C. Expenditures Other Than Salaries (cont'd) - Interest

Name of Facility	License No.		Report for Ye	ar Ended		Page	of
Meriden Care Center, LLC	2448		9/30/2019	u		26	37
Item			Total	CCNH	RHNS	(Spec	cify)
12. Interest						1	
<ul> <li>A. Building, Land Improvem</li> </ul>	ent & Non-Movable						
Equipment							
1. First Mortgage     Name of Lender		\$					
Name of Lender		Rate					
Address of Lender							
2. Second Mortgage							
Name of Lender		Rate					
			_				
Address of Lender							
3. Third Mortgage		\$					
Name of Lender		Rate					
Address of Lender		ı	-				
4. Fourth Mortgage		\$					
Name of Lender		Rate					
Address of Lender		l					
B. CHEFA Loan Information	1						
Original Loan Amount	i .	\$	1				
2. Loan Origination Date							
3. Interest Rate %							
4. Term							
5. CHEFA Interest Expe	nse			7			
12 B7. Total Building Interest Expe		\$					***************************************
12 27. Total Ballating Intel Cat Expe	1100 (211 211 : 135)	ч	· <del></del>	ry Subtatals	<u>C</u> 1.	<u> </u>	

(Carry Subtotals forward to next page)

## C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance

Name of Facility	License No.		Report for Yo	Page of		
Meriden Care Center, LLC	nter, LLC 2448			9/30/2019		
Ite	m		Total	CCNH	RHNS	(Specify)
	Subtotals Brou	ight Forward:				
12. C. Movable Equipment						
1. Automotive Equipment	nt	\$				
A. Item	Rate	Amount				
Lender		WWW				
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equip	ment Interest					
Expense (C1 + 2)		\$		-		
12. D. Other Interest Expense (	Specify)	\$	12,931	12,931		
INTEREST						
100 M 1 411 T 1	1000 1000 1000					
13. Total All Interest Expense (	12B7 + 12C3 + 12D)	\$	12,931	12,931		
14. Insurance		A	0.045			
a. Insurance on Property (b		\$		9,367		
<ul><li>b. Insurance on Automobile</li><li>c. Insurance other than Pro</li></ul>		\$				
c. Insurance other than Proj 1. Umbrella ( <i>Blanket Co</i>		•	71.000	71.000		
2. Fire and Extended Co		<u> </u>		71,009		
3. Other (Specify)	iverage	\$		£ 013		
Other insurance, crim	ρ	Þ	6,913	6,913		
Outer mourance, crim						Resident State of the State of
						-
14d. Total Insurance Expenditur		\$		87,289		
15. Total All Expenditures (A-1	3 thru C-14)	\$	14,727,740	14,727,740		

## D. Adjustments to Statement of Expenditures

	e of Fa		enter, LLC	Li	cense No. 2448	Report for Ye	ar Ended	Page 28	 I	of 37
Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS		pecif	***************************************
			es and Wages		Decreuse	CCIVII	IGHAD	(1)	pccn	<i>y )</i>
1.			Outpatient Service Costs	\$				***********		<u> </u>
2.	<b></b>		Salaries not related to Resident Care	\$						
3.			Occupational Therapy	\$						
4.			Other - See attached Schedule	\$						
Page	13 - 1	Profes	sional Fees							
5.			Resident Care Physicians **	\$						*********
6.			Occupational Therapy	\$				-		
7.			Other - See attached Schedule	\$						
Page	s 15 &	16 .	Administrative and General							
8.			Discriminatory Benefits	\$						********
9.			Bad Debts	\$	34,600	34,600	· · · · · · · · · · · · · · · · · · ·			
10.			Accounting	\$						
10a.			Legal	\$						
11.			Telephone	\$					····	
12.			Cellular Telephone	\$						
13.			Life insurance premiums on the life							
			of Owners, Partners, Operators	\$					**********	(000)(000)
14.			Gifts, flowers and coffee shops	\$						
15.			Education expenditures to colleges or							
			universities for tuition and related costs							
			for owners and employees	\$				**********	********	(88)(88)
16.			Travel for purposes of attending							****
			conferences or seminars outside the							
			continental U.S. Other out-of-state							
			travel in excess of one representative	\$						*******
17.			Automobile Expense (e.g. personal use)	<del></del> \$						
18.			Unallowable Advertising *	\$		27,890				
19.			Income Tax / Corporate Business Tax	\$	27,000	17,000			***************************************	
20.			Fund Raising / Contributions	\$			L			
21.			Unallowable Management Fees	\$						
22.			Barber and Beauty	\$						
23.			Other - See attached Schedule	\$		32,043		ļ		
	18 - 1	Dietar	y Expenditures	<del>.</del>	32,013	32,073				
24.			Meals to employees, guests and others							
			who are not residents	\$						
Page	19 - 1	auna	ry Expenditures	Ψ						
25.			Laundry services to employees, guests							
- 1			and others who are not residents	\$						
Page	20 - F	Iouse	keeping Expenditures	Ψ						*****
26.			Housekeeping services to employees, guests							
			and others who are not residents	\$						<b></b>
	<u> </u>	·	Subtotal (Items 1 - 26)	<u>Φ</u>	94,533	94,533				
			Wanted".	ф	<u> </u>	arry Subtotal f		<u> </u>		

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

### Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Othe	r Salaries /	Adjustment	\$ -	<b>s</b> -	\$ -

### Schedule of Fees Adjustments

Line Kei	Description	CCNH	RHNS	(Specify)
· Fees Adjı	ustments	\$ -	\$	\$ -
		Fees Adjustments		

## Schedule of Other A&G Adjustments

Page Ref	Line Ref Description	CCNH	RHNS	(Specify)
16a	PENALTIES	\$ -		ls -
16a	LATE FEES	\$ 394		\$ -
16 <b>a</b>	PRIOR PERIOD EXPENSES			
	rounding	\$ 0		
	Provider User Fee for Medicare days	\$ 31,649		\$ -
Total Othe	r A&G Adjustments	\$ 32,043	<b>S</b> -	\$ -

D. Adjustments to Statement of Expenditures (cont'd)

			D. Adjustments to Statement	nt	of Expend	itures (co	nt'd)		
	of Fa			Lic	ense No.	Report for Y	ear Ended	Page	of
Meric	len Ca	re Ce	nter, LLC		2448	9/30/2019		29	37
					Total				
Item	Page	Line			Amount of	]			
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	(Spe	cify)
			Subtotals Brought Forward	\$	94,533	94,533			
Page	20 - F	<i><b>Reside</b></i>	nt Care Supplies***						
27.			Prescription Drugs	\$				*****************	
28.			Ambulance/Limousine	\$	7,962	7,962			
29.			X-rays, etc	\$	3,446	3,446			
30.			Laboratory	\$	12,600	12,600			
31.			Medical Supplies	\$					
32.			Oxygen (non emergency)	\$					
33.	,		Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$	7,278	7,278			
Page	22 - N	<i><b>Iainte</b></i>	enance and Property						
35.			Excess Movable Equipment Depreciation						
			See Attached Schedule	\$					
36.			Depreciation on Unallowable						
			Motor Vehicles	\$				.00000000000000000000000000000000000000	000000000000000000000000000000000000000
37.			Unallowable Property and Real						
			Estate Taxes	\$				250000000000000000000000000000000000000	
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$					•
	27 - I	nsura	nce						
40.			Mortgage Insurance	\$					******************************
41.			Property Insurance	\$					
	- Mis								
42.			Other - Indirect	\$					***************************************
43.			Interest Income on Account Rec.	\$					
44.			Other - Miscellaneous Administrative	\$					
45.			Management Fees Direct	\$				***************************************	
46.			Management Fees Indirect	\$					
47.			Other - Direct	\$					
Not F	or Pr		roviders Only						
48.			Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
			See Attached Schedule	\$					***************************************
49,	Total	Amou	ınt of Decrease (Items 1 - 48)	\$	125,819	125,819			

<sup>\*\*\*</sup> Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

#### **Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5J		7,278.30		
13	B5A	PT-Resident Care (for outpatient therapy - see schedule)			
13	B9A	ST- Resident Care (for outpatent therapy - see schedule)			
13	B10A	OT-Resident Care (for outpatient therapy - see schedule)			
Total Othe	r Ancillary	Costs	\$ 7,278	\$ -	\$ -

#### Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Exce	ss Movabl	e Equipment Depreciation	<b>S</b> -	\$ -	\$ -

#### Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
					Taraba a la
Total Othe	r Property	/ Adjustments	\$ -	\$ -	\$ -

## Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	4Al	Houskeeping Supplies (for Outpatient Therapy - see schedule)	<b>S</b> -		Data da de la composición dela composición de la composición de la composición de la composición de la composición dela composición de la composición dela composición dela composición de la composición de la composición de la composición dela composición de la composición dela composición dela composición dela composición dela composición dela composición dela composici
20	4B	Housekeeping purchased services (for Outpatient Therapy see schedule)	\$ -		
22	6B	Heat (for outpatient Therapy see schedule)	\$ -		
22	6C	Light and Power (for outpatient therapy see schedule)	\$		
22	6D	water (for outpatient therapy see schedule)	\$ -		
22	6A	Repair&Maint (for outpatient therapy see schedule)	\$ -		
<u> </u>			Principal nema consist		100 p 140 co

					age 29
			iawaning jijugi		
Total Other Adjustm	ients		\$	-   \$	\$

### Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Othe	r Adjustm	ents	\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Othe	r Adjustm	ents	\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
en en 1955 van 196 An January Van Saar					
Total Unal	lowable Bu	ullding Interest	\$ -	\$ -	\$ -

## F. Statement of Revenue

Name of Facility License No.	VCII	Report for Y	ear Ended		Page	of
Meriden Care Center, LLC 2448		9/30/2019		-	30	37
<u>Item</u>		Total	CCNH	RHNS	(Spec	ify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	12,201,718	12,201,718			
b. Medicaid Room and Board Contractual Allowance **	\$					
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$	769,597	769,597			
b. Medicare Room and Board Contractual Allowance **	\$					
4. a. Private-Pay Residents and Other	\$	2,189,202	2,189,202			
b. Private-Pay Room and Board Contractual Allowance **	\$					
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$	69,382	69,382			.,
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(69,382)	(69,382)			
c. Prescription Drugs - Non-Medicare	\$	320,835	320,835			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(146,538)	(146,538)			
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$	121,763	121,763			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(83,360)	(83,360)			
c. Physical Therapy - Non-Medicare	\$	119,587	119,587			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(119,587)	(119,587)			
4. a. Speech Therapy - Medicare	\$	37,592	37,592			
b. Speech Therapy - Medicare Contractual Allowance **	\$	(21,275)	(21,275)			
c. Speech Therapy - Non-Medicare	\$	29,365	29,365			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(29,365)	(29,365)			
5. a. Occupational Therapy - Medicare	\$	129,807	129,807			
b. Occupational Therapy - Medicare Contractual Allowance **	\$	(82,474)	(82,474)			
c. Occupational Therapy - Non-Medicare	\$	144,952	144,952			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(144,191)	(144,191)			
6. a. Other (Specify) - Medicare	\$					
b. Other (Specify) - Non-Medicare	\$	200,177	200,177			
II. Total Resident Revenue (Section I. thru Section II.)	\$	15,637,805	15,637,805			
V. Other Revenue*						
1. Meals sold to guests, employees & others	\$	x+0x2002x+000xx400xx4000x4000			00.000000000000000000000000000000000000	80.000000000000000000000000000000000000
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$				•	
5. Interest Income (Specify)	\$	229	229			
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (Specify)	\$	11,130	11,130			
			,			
V. Total Other Revenue (1 thru 8)	\$	11,358	11,358			

<sup>\*</sup> Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts.

#### Schedule of Other Resident Revenue - Medicare

#### Related Exp

Ref	Description	CCNH	RHNS	(Specify)
	Lab Medicare	\$ 1.16	7	
<u> </u>	Lab Medicurt CA	\$ (3,16)		
	Oxygen Medicare	S 19		100.000
	Oxygen Medicare CA	\$ (19)		
: · · ·	Equipment rental	\$ 821		THE SECTION
	Equipment rental CA	\$ (82)		
	Pen Therapy	\$	Tr. Grady re	10000
	Pen Therapy CA	s -	100000000000000000000000000000000000000	Light A
	Therapy Beds Medicare	s -		
-	Therapy Beds Medicare CA	\$		
	Radiology Medicare	\$ 713	<del>d factorities.</del>	1 1 1 1 1 1 1 1
1	Radiology Medicare CA	\$ (713		V-11 (
. i	IV Therapy	\$ 109		
	IV Therapy CA	\$ (109		10000
1	Medical Transportation	\$ -		
- 1	Medical Transportation CA	\$	V 1981 1981 1981	10000
	Glucose testing	s .		
(	Glucose testing CA	s .		
	Outpatient therapy Medicare	\$	1 1111111111	1
:::			d districtly is	
		<del></del>		1 1 1 2 2 2
Other	r Resident Revenue - Medicare			
Other	Realdent Revenue - Medicare	\$	5	

#### Schedule of Other Non-Medicare Resident Revenue

#### Related Exp

tef	Description		CCNH	RHNS	(Specify)
	Leb		9,017.39	7 h - 1 7 f . 1 h	
	Lab CA		(9,047.39)	33,73,58,54	14   40 PM
	Oxygen	s	980		\$ .
	Oxygen CA	\$	(980)	114441	\$
	Equipment vertei	\$	10,127		11/11/11
	Equipment reotal CA	\$	(10,127)		1
	Pen Therapy	\$		at 14, 4, 7, 54	4.004.00
	Pen Therapy CA	\$			
	Therapy Beds	\$		Attain year of	11.10.10
	Therapy Beds CA	s	100	A334.45 B	1100, 100
	Rudiology	s	2,733	74 FN 16. 3	V 1357546
	Radiology CA	\$	(2,733)	Park Harvey	
	Medical Transportation	\$	14,367		1111111111
<u> </u>	Medical Transportation CA	5	(14,367)	Barana ya 19	61, 5, 93, 54
	Glucose Testing	\$		Ba Yulida	3. 3. 3.
	Glucose Testing CA	5	A	100	
	IV therapy	S	436	10.00	<b>S</b> -
	IV therapy CA	s	(436)		\$
	Flu shot revenue	5	1,672	98: Aspessal	3. 40.70
	Outpatient therapy	\$			
25	Outpatient therapy CA	3			**********
	prior period revenue	s	116,760	11 21 54	70 to 10 to 10
	Ophen B	s	113,367	100 100 100 100	1901 1901
	Optum B CA	\$	(33,867)	3 3 3 6 7 7 7 8	
	C/A VBP	Š	246		*********
			240	70.00	
$\Box$	rounding	\$		S 550,200, 717, 718	y 450 y 150,00
Π		*	Sec. 25		o e partir de la composición del composición de la composición de la composición de la composición del composición de la composición del composición de la composición del composición del composición de la composición de la composición del composición del composición del composición del composición d
hhai	Resident Revenue		200,177		\$

#### Interest Income

#### Account

Page Ref Account	Вајапсе	CCNH	RHNS	(Specify)
INTEREST INCOME		\$ 229		
		A Proposition	New York	313,71.39 %
- 1 A PONE - ACTO AR ACTOR			A THE ACTOR	100000000000000000000000000000000000000
				14-11-25
l'atel Interest Income		S 229	\$	

#### Schedule of Other Revenue

Page Ref	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	CCNH	RHNS	(Specify)
	MEALS	\$	500,000,000	
	TELEVISION INCOME	•	And the state of the state of	
1.31	CONCESSIONS / VENDING INCOME	\$ 209		3 3 4 4 4 4 4
	RESIDENT LATE FEE REVENUE		jelo Beloko	w. Comer.
	RESIDENT ATTORNEY FEE REVENUE	s	neries exi	A sign and a sign
	TELEPHONE INCOME		71.10 11.00	
3.777.63	OTHER INCOME	S 155	10 10 10 10 10 10 10 10 10 10 10 10 10 1	
	OPTIM DRAIDENING DESCRIPTION	\$ 8,225	7345 E. P. E. P.	111111111111111
	OPTUM OUTLIERS	\$ 2,340	1.38 3 St. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	
	OTHER INCOME: DEFERRED REVENUE	\$ 2,340		
77 - 1 1944	ALL DMHAS REVENUE	•	Section 1	
			On all artist	Control Control
atel Othe	r Revenue	\$ 11,130		

## G. Balance Sheet

	of Facility	License No.	Report for Year Ended		
Meride	en Care Center, LLC	2448	9/30/2019	31	
Assets		Account			Amount
	Current Assets				
л. (	Current Assets I.    Cash ( <i>on hand and in bank</i> .	n <b>)</b>		ď	(07)
2	2. Resident Accounts Receiva		for Pod Dobta	\$ \$	2.410.702
	3. Other Accounts Receivable			\$ \$	2,410,792
4		(Excluding Owners (	n Related Parties)	\$	
	5. Prepaid Expenses			\$	820,078
J	a. Prepaid Insurance		780,685	D.	820,078
	b. Prepaid Property Taxes		37,982		
	c. Prepaid Expenses Other		1,411		
	d. See Schedule		1,411		
6	5. Interest Receivable			\$	
	7. Medicare Final Settlement I	Receivable		\$	
	B. Other Current Assets (itemi			\$	(569,799
V	Due From (to) Related Parties		(17,853)	Ψ	(303,133
	Other Owners reserves		(551,945)		
	See Schedule				
A-9. <i>T</i>	Total Current Assets (Lines A	thru 8)		\$	2,661,045
	Fixed Assets			Ψ	2,001,013
1	L. Land			\$	
2	2. Land Improvements	*Historical Cost		\$	
	1	Accum. Depreciat	ion Net	ľ	
3	B. Buildings	*Historical Cost	416,163	\$	315,593
		Accum. Depreciat		T T	3,3,333
4	Leasehold Improvements	*Historical Cost	754,915	\$	325,348
	•	Accum. Depreciat		ľ	5.25,510
5	5. Non-Movable Equipment	*Historical Cost	, , , , , , , , , , , , , , , , , , ,	\$	
	• •	Accum. Depreciat	ion Net	Ť	
6	6. Movable Equipment	*Historical Cost	891,351	\$	213,550
	· · ·	Accum. Depreciat		Ť	_10,000
7	7. Motor Vehicles	*Historical Cost		\$	
		Accum. Depreciat	nion Net	Ť	
8	B. Minor Equipment-Not Depr			\$	
9	Other Fixed Assets (itemize	)		\$	
	Construction in Progress	,		۳	
	See Schedule				
B-10.	Total Fixed Assets (Lines I	31 thru 9)		\$	854,490

<sup>\*</sup> Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

#### Schedule of Prepaid Expenses Page 31 Line A5

Page Rei	Line Ref		
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J. 30			
l Pre	paid Expens	e <del>s</del>	s
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ge Ref	Line Ref	Description	
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ge Ref	Line Ref	Description	F-92-32-3-
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tat Othi	r Assets	able (Hemize) Page 33 Line A2	\$
ial Offici	r Assets	able (Hemize) Page 33 Line A2	\$
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at Othic sector of the sector	I Notes Pay Line Ref  S Payable  F Other Curr  Line Ref  Current Li	able (itemize) Page 33 Line A2  Description  Tent Liabilities (itemize) Page 33 Line A12  Description  shillies (itemize)  general Liabilities (itemize) Page 34 Line B4	3
at Othic sector of the sector	I Notes Pay Line Ref  S Payable  F Other Curr  Line Ref  Current Li	able (itemize) Page 33 Line A2  Description  Tent Liabilities (itemize) Page 33 Line A12  Description  shillies (itemize)  general Liabilities (itemize) Page 34 Line B4	***
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# G. Balance Sheet (cont'd)

Nam	e of	f Facility	License No.	Report for Year Ended		Page	1	of
Meri	den	Care Center, LLC	2448	9/30/2019		32	3	37
			Account			Am	ount	
				Total Brought Forward:	\$	A	3,515,5	35
C.	Le	asehold or like property record	led for Equity Purposes					
	1.	Land			\$			
	2.	Land Improvements	*Historical Cost					
			Accum. Depreciation	Net	\$			
	3.	Buildings	*Historical Cost					
			Accum. Depreciation	Net	\$			
	4.	Non-Movable Equipment	*Historical Cost					•
			Accum. Depreciation	Net	\$			
i	5.	Movable Equipment	*Historical Cost					
			Accum. Depreciation	Net	\$			
	6.	Motor Vehicles	*Historical Cost					
			Accum. Depreciation	Net	\$			
ļ	7.			***	\$			
C-8		tal Leasehold or Like Proper	ties (C1 thru 7)		\$			
D.		vestment and Other Assets						
		Deferred Deposits			\$			
****		Escrow Deposits			\$		338,9	04
	3.	Organization Expense	*Historical Cost					
			Accum. Depreciation	Net	\$			
	4.	Goodwill (Purchased Only)			\$	<del>,,,</del> ,		
	5.	Investments Related to Resid	ent Care (itemize)		\$		84,4	100
		Patient Trust Funds		81,845				
		Long Term Deposit - prim		2,555			*****	
	6.	Loans to Owners or Related	<del></del>		\$			
		Name and Address	Amount	Loan Date				
	7.	Other Assets (itemize)			\$	н	<u> </u>	
		(			ľ			
-		See Schedule						
		tal Investments and Other As			\$		423,3	
<i>υ</i> -9.	10	tal All Assets (Lines A9 + B1	0 + C8 + D8)		\$		3,938,8	39

<sup>\*</sup> Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

## G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year I	Ended	Page	of	
Meriden Car	e Cer	iter, LLC	2448	9/30/2019		33	37
			Account			Ar	nount
Liabilities						· · · · · · · · · · · · · · · · · · ·	
A.	Cu	rrent Liabilities					
	<u>l.</u>	Trade Accounts Payable				\$	405,126
	2.	Notes Payable (itemize)	41.			\$	102,840
		Working Capital Line of Cr	edit	102,840	)		
		M					
		See Schedule		,			
	3,	Loans Payable for Equipme	ent (Current portion	ı) (itemize)		\$	
		Name of Lender	Purpose	Amount	Date Due	*	
					1		
					1		
	4.	Accrued Payroll (Exclusive	l of Owners and/or S	Stockholders only)		\$	455,669
	5.	Accrued Payroll (Owners an				<u> </u>	755,005
	6.	Accrued Payroll Taxes Paya				\$	
	7.	Medicare Final Settlement F				<u> </u>	
8. Medicare Current Financing Payable						\$	
······	9.	Mortgage Payable (Current				8	
	10. Interest Payable (Exclusive of Owner and/or Related Parties)					8	
	11. Accrued Income Taxes*					5	
	12.	Other Current Liabilities (ite	emize)	, , , , , , , , , , , , , , , , , , ,		}	2,224,009
		Related Party Payables	1,158,	462			-, · <b>,</b>
		Accrued Expenses	41,	996			
		Accrued Resident User Fees	295,	562			
	T	Accrued Workers Comp Expense	727,	989 See Schedule			
A-13.	I ot	al Current Liabilities (Line	s A1 thru 12)		9	S	3,187,644

<sup>\*</sup> Business Income Tax (not that withheld from employees). Attach copy of owner's Federal Income Tax Return.

# G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page	of
Meriden Care Center, LLC	2448	9/30/2019		34	37
	Account			Amo	
		Total Broug	ht Forward:	***************************************	3,187,644
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment			\$		
Name of Lender	Purpose	Amount	Date Due		
			]		
			ļ		
2. Mortgages Payable			\$		
Loans from Owners or Relation	ated Parties (itemize	.)	\$		····
Name and Address of Lender					
	1 44404111	Eoan D	ato		
4. Other Long-Term Liabilitie	s (itamira)				01.045
Patient Trust Funds	3		81,845		
See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)					81,845
C. Total All Liabilities (Lines A-	(3 + B-5)		\$		3,269,490

## G. Balance Sheet (cont'd) Reserves and Net Worth

Name of Facility			t for Y	Year Ended		Page	С	of		
Meriden Care Ce	nter, LLC	2448	9	9/30/2	2019			35	3	7
		Account						Ar	nount	
A. Reserves										
1. Reserv	e for value of leased la	and					\$			
2. Reserv	e for depreciation valu	e of leased building	ıgs a	and ap	purten	ances				
to be a	nortized						\$			
3. Reserv	3. Reserve for depreciation value of leased personal property (Equity)						\$			
4. Reserv	e for leasehold real pr	operties on which	fair	rental	value i	s based	\$	1444 S. M.		
5. Reserv	e for funds set aside a	s donor restricted					\$			************
6. Total R				······································			\$			
B. Net Worth										
1. Owner	s Capital						\$		25,00	00
2. Capital	Stock						\$		***************************************	
3. Paid-in	Surplus						\$		-	
4. Treasu	y Stock						\$			
5. Cumula	nted Earnings						\$		(277,07	74)
6. Gain oi	Loss for Period	10/1/20	18	1	thru	9/30/2019	\$		921,42	23
7. Total N	et Worth					***************************************	\$		669,34	49
C. Total Rese	rves and Net Worth						\$		669,34	49
D. Total Liab	llities, Reserves, and	Net Worth					\$		3,938,83	39

# H. Changes in Total Net Worth

		License No.	Report for Year	Ended	Page	of
Meriden C	are Center, LLC	2448	9/30/2019		36	37
		Account			A1	mount
A. Balar	Balance at End of Prior Period as shown on Report of 09/30/2018				\$	
	l Revenue (From Statement of A				\$	15,649,163
	l Expenditures (From Statemen	nt of Expenditures Pag	ge 27)		\$	14,727,740
	ncome or Deficit				\$	921,423
E. Balar					\$	921,423
1. A	1. Additional Capital Contributed (itemize)					
F-3. Total	F-3. Total Additions				<u> </u>	
G. Dedu	ctions				•	
	Prawings of Owners/Operators/			]:	\$	
	Name and Address (No., City,	State, Zip)	Title	Amount		
2. O	ther Withdrawings (Specify)			5	\$	
	Purpose	Amount				
	otal Deductions				5	
H. Balar	nce at End of Period	09/30/19	)			921,423

# I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Report for Year Ended Page					
Meriden Care Center, LLC	2448	9/30/2019	37	37				
	Check appropriate category							
Chronic and Convalescent Nursing Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)	□ (Specify)	(Specify)					
Preparer/Reviewer Certification								
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.								
Signature of Preparer	Title	Date Signed	****					
Printed Name of Preparer								
iCare Management, LLC								
Addres Address	Phone Number	Phone Number						
341 Bidwell Street, Manchester, CT 06040	860-570-2140	860-570-2140						
Contacted Person Regarding Additional Info	Phone Number	1	-					
Contact Email Address								